PriMera Scientific Surgical
Research and Practice
Volume 4 Issue 2 August 2024
ISSN: 2836-0028

PriMera Scientific Publications

Handbook of Medicolegal Cases

Type: E-Book
Received: July 09, 2024
Published: July 25, 2024

Citation:
Mohd Sarwar Mir., et al. "Handbook of Medicolegal Cases". PriMera Scientific Surgical Research and Practice 4.2 (2024): 36-66.

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Chapter 1: General Guidelines

Most Important Duty

The first and foremost duty of the treating doctor is to save the life of a patient and give necessary urgent treatment. Police should be informed as early as possible but the patient should not be allowed to suffer. For this he must not wait for the arrival of police.

Definition

Medicolegal case is a case of injury ailment where an attending doctor after taking history and clinical examination of the patient, thinks that some investigations by law enforcing agencies are essential so as to fix the responsibility regarding the case in accordance with the law.

Following category of cases be labeled as medico-legal.

1. Road-side accidents, factory accidents or any other unnatural mishap.
2. Suspected or evident homicides or suicides, including attempted.
3. Suspected or evident poisoning.
4. Burn injuries due to any cause.
5. Injury cases where there is likelihood of death in near future.
6. Suspected or evident sexual offences.
7. Suspected or evident Criminal abortions.
8. Unconscious cases, where cause of unconsciousness is not clear.
9. Cases brought dead with improper history.
10. Cases referred by court or otherwise which require age certificate.
11. Cases pertaining to dowry Act, Domestic violence and violence against child.
12. Cases of human rights violation.
13. Cases pertaining to Elderly abuse.

Registration of Medicolegal Case in a Hospital

1. It is purely the responsibility of treating doctor in causality or outpatient of a hospital to decide when to label a case as medico-legal.
2. Request of the patient or the accompanying relative or friends etc. for not registering the case as medico legal shall not be entertained. The Medical Officer/Resident doctor has to base his decision on the nature of circumstances.
3. The cases whether brought by police or by somebody else must be registered as medicolegal in the emergency department if not registered elsewhere.
4. Any case mentioned in the above list even if several days after the incident by police shall be registered as medicolegal. At this period opinion regarding the case is to be given according to the present condition of the patient.
5. In case Medical Officer/Resident doctor has not labeled a case as medicolegal in emergency, but indoor doctor thinks so, he should inform the same to the concerned hospital authorities, Duty Officer on duty must go ahead in fulfilling the formalities including making of an injury report as per his examination findings.
6. In any case registered as medicolegal in one hospital and referred to another hospital, a fresh injury report need not be prepared, although case is labeled as medico-legal for other formalities. The referral slip be attached on the medicolegal report form.

Medicolegal Cases Brought by Police

The Medical Officer/Resident doctor on duty for medicolegal work should ensure that requisition form is received from Investigating Officer or Station House Officer, giving brief facts of the case [1]. This is important for the ends of justice and will help the Medical Officer in conducting examination.

Intimation of Medicolegal Cases to Police

Whenever a suspected medicolegal case is brought in the emergency/OPD, it shall be the duty of the Medical Officer/Resident doctor on duty to send information to the police station/post of the area. Information shall be sent to the police by the quickest possible means. Acknowledgement from the police officer receiving the information will be kept in the file of the patient and in other OPD cases it shall be pasted in the OPD register or with the Medical Officer for further reference [2]. The Medical Officer/Resident doctor will make a note in the file of the patient as to the time and date of informing the police. Medical Officer/Resident doctor will then make a complete record of all injuries and also note the date and time of admission of the case therein. Name and addresses of the attendants who brought the patient should also be recorded in the file and admission O.P.D. register if possible. The Medical Officer will also mark with red pen on the top of first page of the file of the patient the letters “M.L.C.” or put the stamp “Medicolegal case”. The stamp should be kept with the staff nurse on duty in the emergency [3]. The Medical Officer will also see that the card of the patient is marked/stamped “Medicolegal case” by the duty staff nurse on duty.

Discharge of Medicolegal case

1. In each and every medicolegal case who is going to be discharged, an information regarding the day of discharge be given to police at least 24 hours before the discharge period.
2. Immediate information be sent to police, if a medico-legal case (patient) leaves or absconds hospital against medical advice (L.A.M.A).

Emergency Surgery

When emergency surgery is required and no attendant is available to give the consent, the surgeon and emergency medical officer will decide and may conduct an emergency surgery on the patient. Please note that the surgeon treating the case will be held responsible if such a patient dies for want of operative treatment because of the non-availability of attendant to give consent for surgery [4].

Taking away a Patient or Body of a Medicolegal Case Forcibly by the Attendant

The Medical Officer cannot act as a security staff or police officer. He cannot forcibly detain a medicolegal case or his body. In case the attendants want to take away a medicolegal case/body, the implication of their action should be explained to them politely. If they still insist, the Medical Officer/Resident doctor should get it in writing from the attendants that they are taking away the patient/body against medical advice. If they refuse to write anything and take away the patient/body, the Medical Officer should record the same on the file of the patient. In such cases, the doctor in charge of the case, Medical Superintendent/SMO/MO Incharge/RMO, Police Station/ post of the area and security staff be informed immediately

Clothes in Medicolegal Cases

Details of clothing including color, condition, size etc. should be written in the MLR. Torn/damaged/stained etc portions should be encircled with signature. Clothes in medico legal cases involved in rape, stab injuries, fire arm injuries, burns, unidentified dead body etc. should be made into a parcel, sealed and handed over to the police. Clothes of accident victims are not to be preserved unless asked for by the police [5].

Hospital Record

Original hospital record/file of the medicolegal case should not be handed over to the police authorities. If the police requests M.S/ RMO/SMO/MO I/c for the original record of a case, they should be given a photocopy instead. At times, the Courts ask for the original record. In such cases, duplicate/photo copy shall be retained for record. The original file/X-Ray plates are then submitted to the Court under a sealed cover

Chapter 2: Preparation of Medicolegal Report

A medico-legal report comprises of three parts:

a. Preamble: which contains the date, time place of examination, name of the person, the person who brought the case and the person who identified.
b. Findings/Observations: this includes description of injuries and description of other examination/observation made on the patient.
c. Opinion: In this part based on the findings and observations, the medical officer/resident doctor will opine regarding the nature of injuries, that is simple or grievous, the nature of weapon and any other information that may help the investigations.

Preparing the Report

1. Consent - Always take the consent of the injured person on the medicolegal report. If the patient is less than 12 years, take the consent of the guardian/accompanying person and get his signature/thumb impression; consent is not required in case of accused person u/s 53 and 53A of Cr. P.C. and even reasonable force can be used for his examination on the request of the police official not below the rank of a Sub Inspector. If an unconscious/semiconscious patient is brought in emergency along with family/guardian, the consent shall be taken from them. In case of refusal by the family/guardian the medical officer/Resident doctor shall mention on the medicolegal report that the consent could not be recorded [6].
2. The medicolegal report must be prepared by Medical Officer/resident doctor for all cases whether requiring admission for treatment in the emergency department or not. The injury report should be written in a neat and legible handwriting by the examining Doctor himself. Medical Officer/Resident Doctor who first examines the case, shall prepare the medicolegal report. However, in difficult cases, the Medical Officer/Resident doctor should take the help of another Medical Officer or Sr. Medical Officer or consultant for conducting the medicolegal examination or for preparing the medicolegal report.
3. Report should be completed as early as possible after examining the person and taking life-saving measures where required.
4. The preliminary information like name, age, sex and address etc. should be properly filled.

5. Name, relation and address of the accompanying person must also be recorded before letting them go.
6. If accompanied by police officer, his name, rank, number and police station should be recorded.
7. Time of examination along with date of examination must be indicated clearly.
8. Two copies of medico-legal injury report should be prepared. The original copy should be handed over to the police while the office copy should be retained in the register for record.
9. In all such reports, full name of the Medical Officer/resident doctor should be written in block letters below his signatures. Stamp of attending doctor should also be affixed.
10. In case where the nature of injury cannot be ascertained, patient must be kept under observation and admitted in appropriate ward and the same may be mentioned in the medico- legal report.
11. In case where the condition of the patient is so serious that he does not warrant preparation of detailed injury report in the emergency, such detailed report should be prepared in wards by the treating doctor. The Casualty Medical Officers/resident doctor in such cases should mention on their injury report forms the general condition of the patient and indicate that detailed examination and report is to be prepared in the ward.
12. Before examining the person a short history regarding the incidence should be mentioned. If patient is not a fit condition then name and the address of the informant should be mentioned and his version of the incident be taken.
13. General physical examination should always be undertaken and findings like mental status, pulse, Blood Pressure, Respiratory Rate, Pupils etc. be recorded in the injury report.
14. Two identification marks like scars, moles or tattoo marks preferably on the exposed parts of the body should always be recorded.
15. While describing an injury, its type (i.e. abrasion, contusion or laceration etc.), dimension i.e. length, breadth and depth (depth should be mentioned where possible, in case of stab injuries measuring for depth is not available) and location (along with position from a bony point) must be mentioned.
16. Where possible opinion regarding the nature of injury (simple or grievous) should be mentioned but in case it is not possible, reasons should be given e.g. opinion reserved pending CT report, of the patient under observations. In such cases the opinion may be given at a later date [7].
17. As per section 320 of the Indian Penal Code, only the following kinds of hurt are designated as «grievous»,- i. Emasculation. ii. Permanent privation of the sight of either eye. iii. Permanent privation of the hearing of either ear. iv. Privation of any member or joint. v. Destruction or permanent impairing of the powers of any member or joint. vi. Permanent disfiguration of the head or face. vii. Fracture or dislocation of a bone or tooth, and viii. Any hurt which endangers life or which causes the sufferer to be during the space of twenty days in severe bodily pain, or unable to follow his ordinary pursuits [8].
18. While interpreting the weapon of offence the opinion should be given in the form of hard blunt weapon, soft blunt weapon, cutting weapon, stabbing weapon or fire-arm etc.
19. While mentioning the age of injuries, findings like fresh hemorrhage, clot formation, color of scab, color changes in bruise healing, findings of pus formation etc. should be taken into account.
20. Investigation when required (like X-ray examination in suspected fracture cases) must be undertaken and to be recorded in medicolegal report. If referred for investigations, the concerned department should submit the reports regarding the investigation as early as possible to the referring medical Officer/Resident doctor to expedite the completion of medicolegal report by the concerned doctor who prepared the medicolegal report. Failure to do so may prove negligence. In case is referred for opinion, the opinion is to be written on the medicolegal report form [9].
21. Any material (like bullets) gastric lavage fluid, weapons found on the body etc. should be mentioned in the report and handed over to the Investigating Officer under sealed cover. Where clothes are blood stain, these should be taken possession of by the medical officer/resident doctor and sent to Police station in sealed cover with a mention of it in the report.
22. Death summary to be prepared in duplicate, one copy to be issued to the Police.
23. All medico-legal reports, register shall be kept in proper safe custody under the Medical officer/Resident doctor till completed and then sent to record section [10]. There should not be access to any unauthorized person to these documents and should be

kept with an official deputed by the hospital so that it is not tampered with. It shall be given to authorized public officer by that official only.

24. In case where an opinion was kept pending subsequent opinion on the report is given at an appropriate time, after going through the earlier report. This opinion be also sent to the record section from where it will be issue to the police.
25. Examining female patients in the presence of the attendant/relative/guardian. A female patient, even if she is not a medicolegal case, should not be examined without the presence of a relative of the patient or a woman hospital attendant.

Poisoning Cases

1. In suspected poisoning cases, (where required and indicated) gastric lavage should be done.
2. Give details of symptoms and probable nature of poison used.
3. Stomach wash, urine, blood etc. in poisoning cases must be collected and preserved in bottles which should be properly sealed, labeled and made into a parcel.
4. The sealed parcel along with a letter and a copy of medicolegal report is sent through the police official concerned to the forensic sciences laboratory through police for detection of suspected poison.
5. The letter should give particulars of the case, details of the bottles, sample impression of the seal put on the bottle and the poison suspected.

Firearm Injuries

1. In case of fire arm injuries, blackening, tattooing or singeing if present should be mentioned
2. Wound of entry, wound of exit if present is also required to be mentioned.
3. Bullets, lead shots etc recovered from the wounds or body in fire arm injury cases should be put in a bottle(s), sealed and handed over to the police at the earliest under proper acknowledgement.
4. Details of all such recovered material should be mentioned in the medicolegal report.
5. If the parcel is not collected by the police within reasonable time frame, the Medical Superintendent/CMO and also the district SP are informed about the delay.

Rape/Sexual Assault Cases
Sample Collection for Forensic Science Laboratory

1. Samples are to be collected as per the protocol and packed in the envelopes provided in the SAFE kit.
2. Envelopes are numbered. The number matches with the corresponding step number in the protocol.
3. In some cases, you may not need all the envelopes in the kit. For example, if no debris are found on the body surface, envelopes titled ‘Debri Collection’ will not be required. ‘No Specimen’ will be written across the label on such envelopes.
4. In other situations, you may need extra supplies. Envelopes and supplies have been provided in the kit to cater to the basic minimum requirements. Use more envelopes, slides, oral swabs, vials etc. from the hospital supplies depending on the requirement.
5. All the envelopes in the kit are self sealing.

Steps in Examination of Victim

Consent: A written information be taken from the victim. The identity and purpose of examination should not be disclosed to unrelated person. The record should be kept in proper custody and supervision. The following details to be noted name, parentage, Address, Age, Martial Status, occupation. height, Weight, Current medication (if any),date and time of arrival, place of examination, date and time of Starting Examination, date and time of completing examination.

History

a) Marks of Identification.

b) History/Brief description of the incident (as narrated by the victim).

General Physical Examination

1. Physical development.
2. General condition of the person.
3. Gait of the victim.
4. Behavioral Symptoms.
5. Condition of various clothes.
    a) Tears/Cuts/rents.
    b) Foreign matter.
    c) Stains.
        i) Blood.
        ii) Seminal.
        iii) Faecal.
        iv) Mud.
    d) Burns.
    e) Buttons (intact/undone/broken/torn).

Examination of Injuries

(Sample collection for Forensic Science Laboratory from the body parts to be examined must be accomplished before the digital examination of that part of the body).

1. Location of injury.
2. Type of injury (Bruises, abrasions, bite marks, cuts etc.).
3. Dimensions (length, breadth, depth, shape, margins & directions).
4. Stage of healing.
5. Simple/grievous/dangerous to life.
6. Cause of injury.
7. Details regarding penetration.

Local Examination of Genitalia

A. For use in Adult Females only
    1. State of the Tops of Thighs, Pubic Region and Perineum.
    2. State of the sphincters.
    3. State of perineal musculature, Labia Majora, Labia Minora, Fourchette and introitus, Anus and Rectum.
    4. Per Vaginum Examination.
    5. Per Speculum examination …
    6. State of Hymen (only if relevant).

In the case of Pre-Pubertal Female

1. State of the Tops of Thighs, Pubic Region and Perineum.
2. State of the sphincters.
3. State of perineal musculature, Labia Major, Labia Minora, Fourchette and introitus, anus and rectum.
4. P/Vaginal digital examination only if relevant.
5. P/Vaginal speculum examination only if relevant.

Local Examination of Genitalia

(For use in male victims only): The following points need to

1. State of the Penis and testicles.
2. State of anal area including sphincters.
3. State of perineum and perineal musculature and other injuries.
4. Proctoscopy Findings.

Summary of Examination of Victim

1. Step 1 - Consent.
2. Step 2 – History.
3. Step 3 - a. Clothing outer b. Clothing inner.
4. Step 4 - Debris collection (5 Envelopes).
5. Step 5 - Breast Swab.
6. Step 6 - Combing pubic hair.
7. Step 7 - Clipping of pubic hair.
8. Step 8 - Matted pubic hair.
9. Step 9 - a. Cervical mucous collection b. Vaginal secretion collection.
10. Step 10 - Culture.
11. Step 11 - Washing from vagina.
12. Step 12 - Rectal examination.
13. Step 13 - Oral Swab.
14. Step 14 - Blood collection EDTA, Plain.
15. Step15 - Urine Sample Collection.

Opinion: The components of opinion include

1. Age of survivor.
2. Evidence of injury if any.
3. Evidence of intercourse.
4. Evidence of child sexual abuse.
5. Investigation (Lab and Radiologist).
6. Opinion after receiving laboratory test reports.

Chapter 3: Dealing with the Dead

Whenever a medicolegal case dies, the police officer I/C of the police post/police station of the area should be informed immediately and a note to the effect be recorded on the file of the deceased.

When the body of a medicolegal case is sent to the mortuary, clear instructions should be given to the mortuary attendant, not to hand over the body to the relatives without post mortem. Complete chain of custody of the dead body shall be maintained at all times until the time the body is finely handed over to the relatives of the deceased. The body shall be transported to the mortuary. Name of the ward attendant or any other employee/police staff transporting the dead body shall be recorded in the file or in the OPD register. Once the information is received by the police and the police official has arrived at the hospital, he shall be responsible along with the hospital staff for the safety of the dead body. It shall be ensured that samples remain intact, shall not be tempered at all times. Death certificate should not be issued in Medico-legal cases by the doctor conducting the Post- Mortem examination. Only the Hospital registry should do so.

Disposal of Patients Who on Examination are Found Already Dead on Arrival in the Casualty (Brought in Dead)

1. All cases brought dead must be registered as medicolegal in the casualty, along with all possible details about the deceased obtained from the persons accompanying. Addresses of persons bringing such a dead individual must always be noted.
2. In all such cases registered as medicolegal information to police be sent.
3. While preparing casualty card, it must be mentioned that the deceased was 'brought dead'. Also, mention the date and time when the deceased was brought to casualty.
4. All such bodies should not be handed over to the relatives, but sent to mortuary. They should only be handed over to appropriate police authorities.

Disposal of bodies in Medicolegal Cases Dying in Casualty/Wards

1. All dead bodies of medico-legal cases that expire in a casualty/ward should be sent to the mortuary of the hospital for onward handing over to police.
2. All dead bodies of medicolegal cases be handed over to a police officer not less than the rank of A.S.I for inquest
3. In no case such bodies be handed over to relatives directly. However, relatives must be informed accordingly.
4. In case relatives are not present, police officer should be informed and intimation be sent to the relatives through them.
5. A "death summary' in duplicate should be prepared by the Medical Officer attending such cases and one copy should be handed over to the police officer who receives the dead body of the deceased and second copy attached to the case records.

Dying Declaration

The dying declaration is defined as "A statement written or verbal, made by a person who is dying as a result of some unlawful act relating to material facts of the cause of death or circumstances surrounding his death", and is admissible as evidence in case in which the cause of that person's death is the subject of enquiry. In case person who has sustained the serious injuries and is in danger of life or likely to succumb, the medical officer should inform the magistrate so that the dying declaration of the person is recorded. In case it is expected that this person will die before the arrival of Magistrate, the medical attendant can record the Dying Declaration himself. It is better to take the written statement of the person making declaration otherwise it should be recorded in the identical words of the person. No suggestion should be made to the person and no attempt should be made to seek information by asking leading questions. The contents of the declaration should be read over to the dying individual and if possible it should be signed by the declaration. Further, It should be attested by the write and signed by the witnesses present. After recording the declaration, it should be forwarded to the Police or to the Magistrate under who is conducting the inquiry of the case. Prior to the recording of Dying declaration, the attending doctor is required to issue a certificate of the "*compos mentis*" to give dying declaration. The Medical Officer should be careful while issuing such a certificate as he will be summoned to the court of law.

Role of Mortuary

In a hospital mortuary, dead bodies dying in the Hospital are kept and preserved properly, before being handed over to the relatives of the deceased. In Medico-legal case, it is to be ensured that the bodies are not to be handed over to the relatives but to concerned Police personnel for inquest and subsequent post-mortem, if required.

Unclaimed Cases

In all unclaimed cases and unknown death cases, it is mandatory to preserve the dead bodies for a period of at least 72 hours before it is handed over to religious organizations/municipal bodies for last rites after obtaining proper permission through police from district magistrate. In case these bodies get identified, they are handed over to relatives concerned after noting the same fact on the death certificate.

Mortuary Register

Maintaining records in relation to storage of dead bodies and their disposal at mortuary is a very important function. A mortuary register indicating all the details of the case in various columns, so that proper identity could be traced when required, should be available.

1. The date and time of receipt of the body in mortuary and its disposal should be also be mentioned on the said register together with signature of the person whom the dead body has been handed over to.
2. A serial number should be allotted to each dead body and the same be affixed against the cabin where dead body has been kept.
3. In no case any dead body should be stored in the mortuary without entering in the register.
4. Outside hospital dead bodies can be preserved in cold storage after permission from hospital authority concerned for this purpose.

Preparation of Post Mortem Report

A medicolegal post mortem should be conducted only when there is official order from police or magistrate

1. All Registered Medical Practitioners (RMPs) in government service can conduct the post mortem.
2. Autopsy should be conducted by Board of doctors (ideally odd number) in case of dowry death, custodial death or death on operation table, second autopsy, exhumation.
3. No unauthorized person should be present in the mortuary during autopsy.
4. Autopsy should be conducted in authorized Centre.
5. Body of deceased should never be embalmed before autopsy since the histopathological examination (HPE) will be impossible.
6. Autopsy should be performed as soon as possible after receiving the requisition from concerned authority without any undue delay.
7. Requisition should be accompanied by copy of request report, dead body challan and any other paper of importance. However, it should be kept in mind that request report may have scanty, misleading or incorrect history.
8. Autopsy should be conducted in day light. Moreover, autopsy is not an emergency, unless there is serious threat to law-and-order situation or instruction comes from concerned District Magistrate (DM).
9. Post mortem for organ donation should be done on priority and can be conducted even after sunset if adequate infrastructure is available.
10. If the dead body is received in mortuary at night, it should be preserved at night at 4-degree temperature after noting exact time of death. “Rectal temperature of the body and Extent of PM staining and Rigor Mortis” should be noted down immediately and the actual post mortem should be done on next day.
11. A police officer or any authorized person and two (2) relatives should identify the dead body.
12. If the body remains unidentified before post mortem examination, then samples (hair with scalp, tooth or in case of infant clavicle or femur) should be taken and preserved in paper bags for future DNA analysis. (No preservatives to be used)
13. Medicolegal Autopsies do not require consent of the relatives.
14. Chain of evidence should be maintained during autopsy.
15. All the articles removed from the body e.g. clothes, jewelry, watches, bullets, pallets, foreign bodies etc. are to be labelled, sealed, mentioned in the report and handed over to the police personnel after obtaining receipt.
16. After completion of the autopsy the body is to be stitched, washed and restored to the best cosmetic appearance and handed over to the investigating officer (I/O).

Preservation of Viscera

Supreme Court of India has ruled that in case of death due to suspected poisoning, the prosecuting agency should send Viscera to Forensic Science Laboratory (FSL) immediately after completion of the autopsy.

Preservation should be done in each and every case.

Following samples are to be sent to Forensic Science Laboratory (FSL).

1. Stomach (whole) with its contents.
2. Upper part of the small intestines (15-30 cms).
3. Liver (100 gm).
4. Half of each kidney.
5. Blood (10 ml).
6. Urine (100 ml).
7. Sample of preservative.

Samples which are sent to FSL should be preserved in saturated solution of common salt.

Following samples are to be sent for Histopathological Examination (HPE).

1. Heart (whole).
2. Piece of liver, lung.
3. Spleen.

Samples sent for HPE are to be preserved in formalin.

In case of Road Traffic Accidents (RTA) CT of whole body should be done before actual autopsy.

Chapter 4: Court Proceedings

In the Indian Evidence Act 1872, Indian Evidence (amendment) Act 2003 and Code of Criminal Procedure 1973 deal with the issues of evidence.

Definition

Evidence is the statements that are made before the court by the witness regarding to the matters or fact under enquiry. These statements are called oral evidence while the documents produced for the inspection of the court are called documentary evidence (IEA Section 3). Thus, the evidence could be either an oral evidence or documentary evidence.

Classification

1. ***Direct Evidence*** - The direct evidence could be oral or documentary. It relates to the fact which is directly seen, heard or perceived by the witness and deposed in the court as oral evidence. Direct Documentary evidence is when facts relating a document are verified by the witness.
2. ***Indirect or circumstantial Evidence*** - It means when the circumstances interferential prove the occurrence of a principal fact eg. X has shot Y in a room. Z saw the X with a fire arm weapon outside the room a minute before the fire in the room. The Z has not seen X firing but his observation circumstantially relates to the principal act of firing the Y.
3. ***Hearsay Evidence*** - It means the information, knowledge, experience gathered from others. The hearsay evidence is not of much value in the court of law.
4. ***Prima fasciae Evidence*** - It is evidence that is considered as a proof on its face value regarding the fact.
5. ***Material Evidence*** - It is evidence in connection with the principal fact having substantial and relevant bearing on the decision making by a material object. While recording of oral evidence if it refers to the existence of any material thing, the court may ask for its inspection eg. Clothing's, weapon of offence, part of poison or any other exhibits.
6. ***Original Evidence*** - It is an independent probative force of its own or is relevant proof by itself.

7. ***Derivative Evidence*** - It is a probative force from some other source or becomes relevant proof through its relation to certain other facts.
8. ***Relevant Evidence*** - It is an evidence that has a direct bearing upon the fact in issues in a case.
9. ***Conclusive Evidence*** - It is evidence that by itself proves the fact in issue in a case, excluding all other evidence.

Recording of Evidence in Court of Law

Oral Evidence

In a court of law, all facts, except the contents of documents or electronic records may be proved by oral evidence (I.E.A Sec.59). The Medical man is usually summoned to the court of law to give the oral evidence regarding the documents/opinion prepared by him. The oral evidence is of more significance as it gives an opportunity to defense counsel to cross examination to clarify the facts. The evidence is recorded in a definite manner as described earlier that is examination-in- chief, cross -examination and re-examination. During evidence any reference made to the material thing, court may instruct to produce the same eg. Weapon, clothing's or any other exhibits for identification and opinion. Therefore, any material/exhibit examined by an expert should be properly sealed and signed or some identification marks put on the exhibit where ever needed along with dimensions recorded so that the exhibit examined is easily identified in the court at the time of deposing the evidence. The special precautions should be taken to maintain the chain of custody, right from the preservation till it is finally produced before the court of law. This is very important and should be invariably followed. While deposing, the witness is permitted to refresh his memory. According to section 159 (I.E.A) "A witness may, while under examination, refresh his memory by referring to any writing made by himself ……………..." He can even refresh his memory by reference to any other document with the permission of court. The medical officer can cite the publications or the opinions of the experts expressed in any treatise or professional treatises. A medical officer though usually appears on behalf of the public prosecutor (State) but he is a witness of Science and therefore, he should express his opinion based on the scientific facts irrespective whether it is supporting the prosecution or defense.

A Mute or Deaf Person may Give Evidence by Signs, Writing or Through an Interpreter

In certain circumstances, the evidence may be admissible without the presence of witness, such as following;

a. Dying declaration (Section 32 and 157 IEA).
b. Expert opinion expressed in a book or treatise, when author is dead or cannot be found (Sec.60 IEA).
c. Evidence of Medical officer recorded in a lower court but Medical officer can be summoned by higher court if any deficiency is observed or needs further explanation (Section 291 Cr PC).
d. Evidence recorded in earlier judicial proceeding when the witness is dead or is not found or incapable of giving evidence or undue delay or unreasonable expenses to call such witness (Sec 33 IEA and Sec. 291 Cr.P.C).
e. Evidence of Mint officers or Indian Security press (Section 292 Cr.P.C).
f. Report of certain Govt. Scientific experts:
    i. Chemical examiner or assistant chemical examiner.
    ii. Chief inspector of explosives.
    iii. Director Finger Print Bureau.
    iv. Director's Central Forensic Science Laboratories or State Forensic Science Laboratory,
    v. Director of Haffkine Institute, Mumbai.
    vi. Serologist to the government (Sec. 293(1) Cr.P.C).
    vii. Public records eg birth and death certificate etc. (Sec. 74, 76, 78 and 35 of IEA), (vi) Hospital records regarding routine entries.

However, in practice Forensic science experts of Central Forensic Science Laboratories and Forensic Science Laboratory are quite frequently summoned to the court of law which is within the rights of the court, prosecution and defense counsel.

Documentary Evidence

Various types of medico-legal documents are issued by a medical expert which are submitted to the courts of law. The medical officer is summoned to prove the contents of the documents either by primary or by secondary evidence

A. ***Primary Documentary Evidence***: Document is produced itself for the inspection by the court (IEA Sec.62)
B. ***Secondary Documentary Evidence***: When certified copies of an original document made in a mechanical process or copies made from or compared with the original or oral accounts of the contents of the documents by some person who has himself seen it (IEA Sec 63). The usual medical documents produced may be as under:
    a. Medical certificates.
    b. Medical Legal records.
    c. Deposition of medical witness taken in lower court.
    d. Dying declaration.
    e. Expert opinion.
    f. Previously recorded evidence.

The evidence is recorded in a particular sequence (Section 138 of IEA) that is:

a. Oath (Section 51 IPC).
b. Examination-in-chief.
c. Cross examination.
d. Re-examination.
e. Question by Judge.

Examination-in-Chief

Oath

It is a verbal promise to tell the truth in the name of God (Allah) taken while holding holy book (Gita, Bible etc.) or old/New Testament.

It is compulsory for the witness to take an oath in the 'witness box' before he/she gives his/her evidence. He/She is required to swear by Almighty God that he will tell the truth, the whole truth and nothing but the truth.

A child less than 12 years need not to take the oath.

Affirmation is verbal declaration, which is made in place of an oath, if the witness is an atheist. It is same as an oath.

Refusing Oath/Affirmation is punishable up to six (6) months of imprisonment with or without fine of up to Rs. 1000/- (section 178 IPC).

Perjury is giving false evidence after taking Oath (Section 191 IPC).

Punishment of perjury (Section 193 IPC) is seven (7) years of imprisonment and fine.

The examination-in-chief is conducted by the counsel who has summoned the witness. Objective of this examination is to place all the relevant and significant facts of the case. In case of expert evidence, his emphasis is on the proper interpretation of facts and opinion given by the expert in the medico-legal report/document. In case of State versus accused cases, this examination is carried out by the public prosecutor. Leading questions are not allowed in this examination. The leading questions are those wherein answer is suggested in the question itself.

Cross Examination

The cross examination is conducted by the opposite counsel. Objective of this examination is to bring forward any fact or opinion that may go in favor of his client. He may attempt to weaken the witness by asking questions which may show contradictions inaccuracies and conflict of opinion. He may also cite literature to prove that the opinion is ill founded. The leading questions are allowed. The witness cannot refuse to answer the questions. In case, he finds it objectionable, he can address the Judge and wait for the directions. Questions asked by the defense counsel can be objected by the public prosecutor. In such situation, medical officer should stop and wait for the instructions from the court. If court says" objection over ruled" he should answer the question. If court says, "Objection sustained" he need not answer the question. There is no time limit. The Examination may last for days together.

Re-Examination

After cross examination if the counsel who has summoned feels that certain obscure points require clarification, he may re-examine the witness but he cannot raise any new issue during re-examination without the permission of Judge and opposite counsel. In case, new issue is raised, the opposite counsel has right to cross examine again on that issue.

Question by Judges

The judge may ask questions at any stage but ordinarily it is observed that they ask some questions after the examination-in-chief and cross-examination is over to clear certain doubts.

After the evidence is recorded, the recorded evidence either typed or computer print at times written in hand is provided to the witness. The Medical officer should go through the evidence and after making necessary corrections sign at the end. He should not leave without taking permission from the court.

Medical Certificates

a. ***Certificate of illness*** - It should mention duration of illness, name and address of the doctor, registration number of doctor, left thumb impression of the patient along with the signature.
b. ***Certificate of insanity*** - to be issued on a prescribed format by a competent authority.
c. ***Death certificate*** - is to be issued by a registered medical practitioner looking after the patient at the time of his last illness, not to be issued if the cause of death is not clear or suspects foul play or he has not seen the patient at least once in last fortnight before death.
d. ***Certificate of Age and Sex*** - to be issued after complete laid procedure and examination (Physical, Dental, Radiological examination, Impression of left thumb, signature of the patient to be recorded).
e. ***Disability certificate*** - to be issued after thorough and complete examination.

Summons

Summon (Section 61 to 69 CrPC) A document compelling the attendance of a witness in the court of law under penalty on a particular day, time and place for the purpose of giving attendance.

It may also be required of him to bring any book, document or other things that he is bound by law to produce in evidence (subpoena duces tecum).

Summon is issued by court in writing, duplicate and signed by the presiding officer of the court and bears seal of the court, crime No: and name of accused person mentioned.

It is served to witness by police officer, officer of court or any other public servant by delivering to him one of the copies of summon.

Witness should sign the receipt on back of the other copy.

Summon can also be served to witness by registered post or fixed on conspicuous part of the house, in which the witness resides.

A summon must be obeyed. A witness will be excused from attending the court, if he has a valid and urgent reason for not being able to attend the said court on that particular date and time.

If witness fails to attend the court;

a. In civil case, he will be liable to pay damages.
b. In criminal cases, the court may issue a notice under section 350 CrPC and after hearing the witness, if it is found that the witness neglected to attend the court without any justification, the court may sentence him to fine or imprisonment or the court may issue bailable or non-bailable warrant to secure the presence the witness in the court of law.

Non-attendance in obedience to an order from court of law intentionally is punishable act with imprisonment up to six (6) months or fine up to Rs. 1000/- to 50,000/- (Section 174IPC).

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GOVERNMENT OF JAMMU AND KASHMIR

HEALTH & MEDICAL EDUCATION DEPARTMENT

POSTMORTEM REPORT

P.M. No:______________________________ Date: ______________________________
Ref: ______________________________

1. **DETAILS OF THE DECEASED/ CASE:**

(a) (Name: (L)______________________________

(b) S/o/D/o/W/o:______________________________

(c) Age: __________ (d) Sex: __________(e) Address:______________________________

(f) Brought by:

(i) Police: ______________________________

(ii) Others: a) ______________________________
b)______________________________

(g) Identified by

(i) Police: ______________________________

(ii) Others: a) ______________________________
b)______________________________

(h) Date & Time of receipt of dead body and papers: ______________________________

(i) Date and Time of commencement of P.M. Examination: ______________________________

(j) Date and Time of completion of P.M. Examination: ______________________________

(k) Place of Examination: ______________________________

2. **RELEVANT INFORMATION AS FURNISHED BY POLICE:**

3. **EXTERNAL EXAMINATION:**

(a) Length: ________________(b) Weight: ________________(c) Physique: ________________

(d) Nutrition: ______________________________

(e) Identification marks: ______________________________

(f) Wearing apparels: ______________________________

(g) Postmortem changes and other appearances of the body: ______________________________

(h) External injuries:

4. **INTERNAL EXAMINATION:**

A. **HEAD, NECK AND SPINAL COLUMN:**

(a) Scalp: ______________________________

(b) Skull: ______________________________

(c) Meninges and Vessels: ______________________________

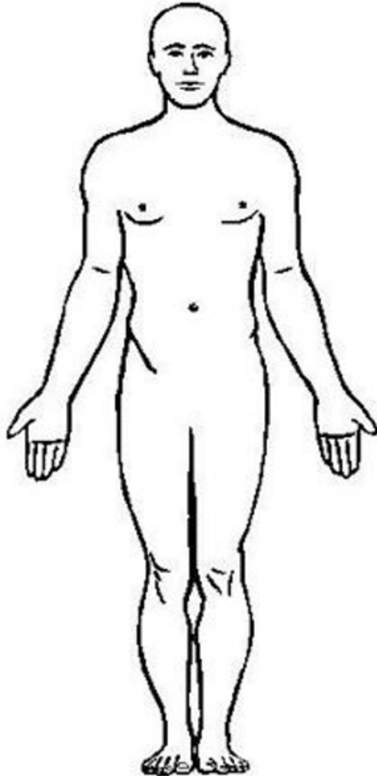
(d) Brain: ______________________________

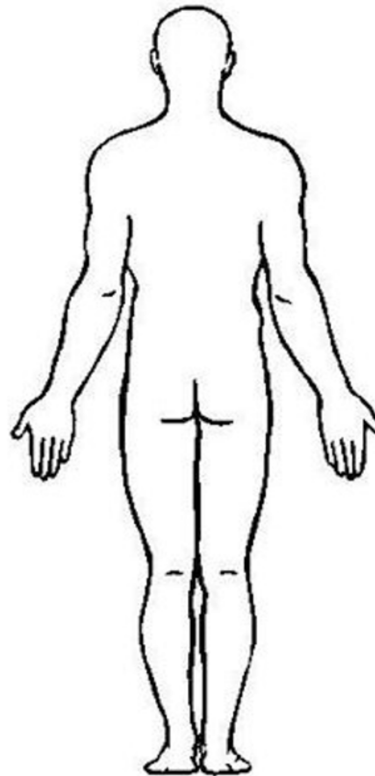
(e) Vertebrae and Spinal Cord (To be opened where indicated): ______________________________

(f) Orbital, Aural and Nasal Cavities: ______________________________

(g) Mouth, Tongue, Pharynx, Larynx and other neck structures: ______________________________

(h) Any Other: ______________________________





B. **THORAX:**

(a) Walls, Ribs and Cartilage: ____________________

(b) Oesophagus: ____________________

(c) Trachea and Bronchi: ____________________

(d) Pleurae and Cavities: ____________________

(e) Right Lung: ____________________

(f) Left Lung: ____________________

(g) Pericardium and pericardial cavity: ____________________

(h) Heart: ____________________

(i) Large Vessels: ____________________

(j) Diaphragm: ____________________

(k) Any other: ____________________

C. **ABDOMEN and PELVIC REGION**

(a) Wall: ____________________

(b) Peritoneum and its cavity: ____________________

(c) Stomach and its contents: ____________________

(d) Small Intestine and its contents: ____________________

(e) Large Intestine and its contents: ____________________

(f) Liver and Gall Bladder: ____________________

(g) Pancreas: ____________________

(h) Spleen: ____________________

(i) Right Kidney and Ureter: ____________________

(j) Left Kidney and Ureter: ____________________

(k) Urinary Bladder and Urethra: ____________________

(l) Organs of Generation: ____________________

(m) Any Other: ____________________

D. **BONES AND JOINTS**: ____________________

5. **SPECIMENS/ITEMS PRESERVED AND HANDED OVER TO INVESTIGATING OFFICER:**

(a) Stomach and its contents

(b) Small intestine and its contents (about 30 cm.)

(c) Liver with GB (about 500 gms)

(d) Spleen.

(e) Kidneys (half of each)

(f) Sample of blood.

(g) Sample of urine.

(h) Sample of hair.

(i) Preservation used: Saturated solution of Sodium Chloride/Rectified Spirit.

(j) Any other: ____________________

(k) Dead body:

6. **SPECIMENS SENT FOR HISTOPATHOLOGY:**

(a) Brain (b) Heart (c) Lungs (d) Liver (e) Spleen (f) Stomach (g) Intestine (h) Kidney (i) Uterus (j) Ovaries

(k) Any other: ____________________

(l) Preservative used: ____________________

7. **OPINION OF THE MEDICAL OFFICER AS TO THE CAUSE OF DEATH:**

(a) Time since death: ____________________

(b) Whether Injuries were antemortem or postmortem:

(c) Cause of injuries: ____________________

(d) Age of injuries (time between infliction and death): ____________________

Place:

Date:

Signature of M.O:

Full Name:

(BLOCK LETTERS)

Designation:

Office Seal:

SUBSEQUENT OPINION (IF ANY):

Sickness Certificate

Name of Patient:____

Age:___________________ Sex_____________________________

Address:____

IPD/OPD No.:_______________ Date_________________________

ID proof type: (Aadhar Card/Driving License): ________ID Proof No._______

Signature or Thumb impression of patient:__________________________

To be filled in by the applicant in the presence of the Government Medical Officer.

Identification Marks.

1_________________________2___________________________

I, Dr………………………………………………………….are careful examination

Of the case certify hereby that……………………..whose signature is given above is

Suffering from………………………………and undergoing treatment OPD/IPD base

from………..to………Consider that a period of absence from duty of …………………

with effect from……………..is absolutely necessary for the restoration of his health.

Place: **Seal** **Signature of Medical officer**

Date: **Registration No…………..**

Fitness Certificate

Name of Patient:

Age: Sex:

Address:

IPD/OPD No.:

ID Proof type : (Aadhar Card/ Driving License) ID proof No.

Signature of Patient or Thumb impression……………………………………………………………………………………

To be filled in the applicant in the presence of the Government Medical officer

Identification Mark:

I, Dr…………………………………………………………………after careful examination

Of the case certify hereby that……………………………..on restoration of health is now fit to resume service.

Place: **Seal** **Signature of Medical officer**

Date: **Registration No…………..**

FORM NO.4 (SEE Rule 7)

MEDICAL CERTIFICATE OF CAUSE OF DEATH

(Hospital In-Patient Not to be used for still births)

To be sent to Registrar along with Form No. 2 (Death Report)

Name of the Hospital___________________________________

I hereby certify that person whose particulars are given below died in the hospital in ward No. ___________on Date / / / at AM/PM

Name of Deceased				For use of statistical Office
Age at Death				
Sex	If 1 year or more, age in years	If less than 1 year, age in months	If less than 1 month, age in days	

Cause Type	**Death of cause Group**	**Death cause Sub-Group**	**Disease**	**Interval between onset and death approx.**
Immediate Cause				
	ICD-	ICD-	ICD-	
	ICD-	ICD-	ICD-	
Antecedent cause				
	ICD-	ICD-	ICD-	
	ICD-	ICD-	ICD-	
Other				
	ICD-	ICD-	ICD-	
	ICD-	ICD-	ICD-	

CAUSE OF DEATH

Manner of Death: Natural How did the injury occur?

Accident

Homicide Dr. Name

Pending investigation Medical attendant Certifying the cause of death

If deceased was a female, was pregnancy the death associated with?

If yes, was there a delivery?

Date of Verification: / /

Injury Report

M.L.C No.________________________________ Date.____________________

Name __________________________S/D/W of____________________(Surname _____Age ______Sex_________

Address ____Police Station________________________________

Date & Time of Examination ____

Mark of identification (at least two) ____

Brief History____

Sr No.	Type of Injury	Size	Situation	Type of weapon used	Nature	Duration	Remarks

LHT Impression of person examined :

Name & Signature of M.O with seal

REPORT OF EXAMINATION OF VICTIM OF SEXUAL OFFENCES

(A) GENERAL PARTICULARS:

MLC No.: ______________________________

Place , date & Time: ____

Brought by: ___________________________________ Ref. by Police Station: _______________________________

Name : ____________________________W/O, D/O:___________________ Sex_________ Age stated _________

Address: ____

Female attendant present : Name ___________________________________ Signature ________________________

Informed expressed consent: ____

Identification Mark: 1. Signature of Left Thumb impression

2.

(B) History:

1. **As per police report :** ____

2. Account given by the victim:

(1) Date, Time & Place of offence:

(2) Date & Time of last intercourse:

(3) Contraceptive used or not :

(4) Position at the time of offense:

(5) Menstruating at the time of offence/ examination.:

(6) In senses / Insensible due to intoxicants / trauma:

(7) Attempts to resist the offence:

(8) Micturated / Not micturated :

(9) Washed the parts / bath taken or not :

(10) Cloths changed / not changed:

(11) Given some thing to ear or drink before sexual act:

(12) After sexual act bleeding / discharged:

(13) Felt sensation of penetration:

(C) GENERAL EXAMINATION:

1. Description of cloths including under garments:
2. Pulse: Blood Pressure:
   Height: Height:
3. Breast:
4. Injuries:

(D) LOCAL EXAMINATION:

Inner aspects of thighs:

Matting of public hair:

Blood/ seminal stain:

Vulva:

Hymen:

Fourchette:

Posterior commissure:

Perineum:

Navicular fossa:

Cervix:

Evidence of venereal disease:

Discharge any other:

(E) SAMPLE COLLECTED FOR LABORATORY EXAMINATION:

1. Cloths- for stains /tear examination:

2. Any loose foreign hair/ fiber:

3. Scalp hair:

4. Nail Scrapping:

5. Saliva- for grouping and secretory / status/ any other comparison:

6. Blood in ETDA bulb- for chemical analysis / any other drugs/ alcohol:

7. Blood in plain bulb- for blood grouping:

8. Public Hair for acid phosphatase / any other:

9. Vaginal smear:

10. Vaginal swab:

11. Urine-for alcohol/ drugs/ grouping:

12. Any discharge-for evidence of venereal disease:

13. Any other:

(F) OPINION:

1.There is evidence/ no evidence of recent vaginal penetration

2. Vaginal penetration has never taken place

3. Evidence of recent vaginal penetration present and is consistent with penetration by penis.

4. Evidence of remote vaginal penetration present and is consistent with penetration by penis.

5. there is evidence / no evidence of injuries due to struggle / resistance.

6. Any other

DATE: **SIGNATURE**

NAME:

Sample of Seal **Designation:**

N.B – copy of report and samples collected are handed over in sealed and labeled condition to P.C/PHC/ASI/PSI____________________ _______ B.No.__________________________ of Police Station_________________________ on date__________for further examination by Forensic Laboratory.

<u>REPORT OF EXAMINATION OF ACCUSED OF SEXUAL OFFENCES</u>

(A) **GENERAL PARTICULARS:**

1. MLC No.: ______________________ 2. Police Station ________________
3. Time: ________________ to __________ 4. Date:__________________
5. Place ____
6. Name: ____________________S/o.________________ Surname_____
7. Address: - ____
8. Age: (As stated by Examine Police) ___________ Years .9. Occupation_____
10. Sent by____
11. Brought By____
12. Informed expressed consent: _____________________________________

____

Signature/ LHT Impression

13. Marks of identification: 1) ____
2) ____

14. History :(Given by Accused):

(a). Vasectomized: Yes or No, If yes – before how many months/ years____

(b). Intoxicated: Yes or No, if yes-Details

(c). Micturated: Yes or No, If Yes-Details

(d). Condom used while sexual intercourse

(f.) Bath taken: Yes or No, If yes-Details ____________ Genital washed: yes or No

(h). Clothes Changed: Yes or No, If yes – Details __________________________

15. History Given by Police____
____

(B) PHYSICAL EXAMINATION:

1. Condition of clothes: (If changed)-Tear/Cuts/Stains______________________

2. Height _______cms. **3**. Weight _______kg. **4**. Built ______________

5. Gait ________________________ **6**. Behavior________________________

7. Dental Status:

Right Upper jaw 87654321 12345678 Left Upper jaw

Right Lower jaw 87654321 12345678 Left Lower jaw

Any other remarks:

8. Hair : a. Scalp
   b. Moustache & Beard
   c. Axillary

9. Ponam admi:

10. injuries on the body with duration (signs of struggle; - bite marks, abrasion, if any)

11. Stains or Foreign material on body:

(C) LOCAL GENITAL EXAMINATION:

1. Public hair:
2. Scrotum: a. (Pendulous or not):
   b. Cremasteric reflex
3. Penis a. Development:
   b. Anomaly :
   c. For skin : Circumcised / not circumcised, if not circumcised then:
   Rolls easily/ Tight/Torn/Phimosis etc.
   d. Frenum-Intact / Torn
   e. Evidence of Venereal disease-Ulcer/ discharge/any other
   f. Glans Penis:
   i Smegma-
   ii Smell
   iii Foreign stain / material-
   iv Seminal blood /any other stain / discharge

4.Injury to public area/penis/scrotum/inner upper part of things

5.Any other remarks:

(D) Sample collected for laboratory examination:

} Clothes – for stains/tear examination.

} Any loose foreign hair /fiber

} Scalp hair:

} Nail scrapping :

} Saliva – for grouping and secretory status / any other comparison

} Blood in EDTA bulb – for blood grouping

} Public hair for acid phosphatase / any other

} Swab from coronal sulcus / glans/ shaft of penis- for vaginal epithelium/ any other

} Urine-for alcohol / drugs / grouping

} Any discharge -for evidence of venereal disease

} Seminal fluid – for grouping & any other investigation

} Any other

(E) Opinion:

1. it is not possible to state whether or not vaginal penetration has taken place recently.

2. I am of the opinion that vaginal penetration has taken place recently.

3. person examined could not have accomplished vaginal penetration by penis.

4. There is nothing to suggest that the person examined is incapable of performing sexual intercourse.

5. Any other-

Date **Signature**

Name :

Sample of seal **Designation:**

NB:- copy of report and samples collected are handed over in sealed and labeled condition to P.C/ PHC/ASI/PSI ____________ B. No _______________ of Police station on date ___________________for further examination by Forensic Science laboratory, Ahmedabad.

Note:1.In case of sodomy look for the presence of lubricant fecal matter specifically. In case of bestiality look for the animal hair, during stains and claw / kick marks of animal.

2. In case of bestiality look for the animal hair, during stains and claw / kick marks of animal.

Age estimation in Male

MLC No: Place:

Time: Date:

Sex: Ref.No:

Name: Age as alleged:

Adress:

Brought & identified by (i)

(ii)

Consent (of Examinee / guardian):

Marks of Identification: 1.

2.

Height__________ Weight ___________General build & appearance________

Chest Circumference _______________________________

{A} Physical Examination: Scalp hair:

Moustache Beard:

Public hair:

Chest hair:

Axillary hair

Pomum adami:

Voice:

Arcus sensilis:

Development of the external genitalia:

{**B**} Dental Examination (Palmer's Notation) Temporary teeth

Permanent teeth

(C) X-ray investigation and findings:

Opinion: From physical, dental & radiological examination of_________________

I am of the opinion that the individual named as above is aged about

____ years.

Place:

Date:

Signature &

Name of Medical Officer

Age estimation in Female

MLC No: Place:

Time: Date:

Sex: Ref.No:

Name: Age as alleged:

Adress:

Brought & identified by (i)

(ii)

Examined in presence of (Female attendant) Name and Signature

Consent (of Examinee / guardian):

Marks of Identification: 1.

2.

Height__________ Weight ___________General build & appearance________

{A} Physical Examination:

Development of breasts:

Date of menarche:

Date of L.M.P:

Hair: Axillary:

Pubic:

{**B**} Dental Examination (Palmer's Notation) Temporary teeth

Permanent teeth

Any additional findings:

(C) X-ray investigation and findings:

Opinion: From physical, dental & radiological examination of_________________

I am of the opinion that the individual named as above is aged about

____ years.

Place:

Date:

Signature &

Name of Medical Officer